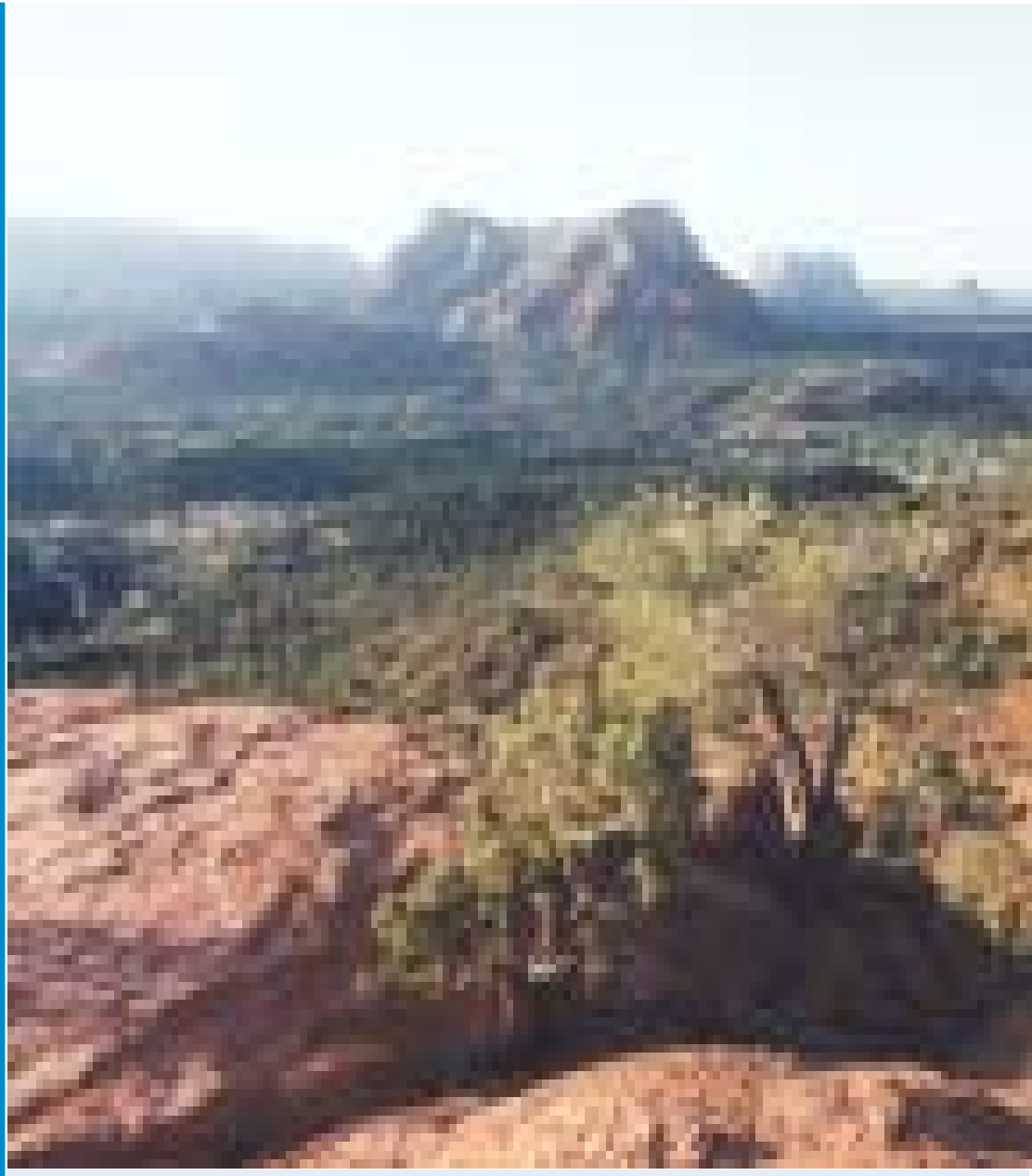
An Overview



Health Care Coverage in Arizona

January 2002

Prepared by

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THE UNIVERSITY OF ARIZONA® HEALTH SCIENCES CENTER

Prepared for

The Arizona Health Care Cost Containment System

Funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA)

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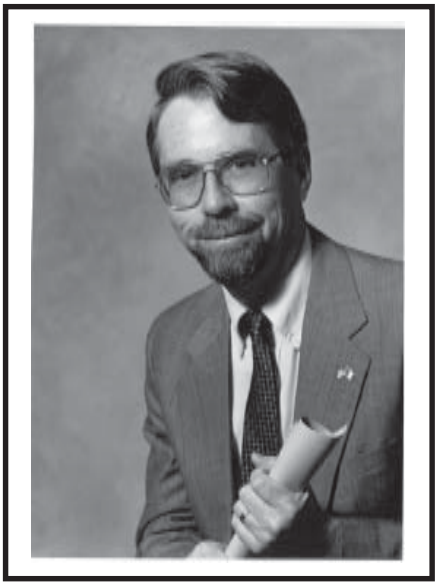
Dedication



Andrew Wilkinson Nichols, MD, MPH
1937 – 2001

The voice is stilled, the light darkened, but the work continues.

This overview is dedicated to the memory of Andrew Wilkinson Nichols, MD, MPH. With the death of Andy Nichols on April 19, 2001, the citizens of Arizona and of the nation, lost a devoted champion. He was a distinguished statesman who approached every task with dedication, enthusiasm, encouragement and creativity.

Andy Nichols knew and loved Arizona. He had the capacity to understand, the wisdom to appreciate and the tenacity to change problems of rural and urban regions and cultures. He combined his medical knowledge with political savvy to benefit the people of Arizona. He was a tireless advocate for the poor, the needy, the sick, the young and the old.

Without Andy Nichols, there might never have been a State Planning Grant in Arizona. Indeed, without Andy Nichols there might never have been a Proposition 204, or any Healthy Arizona Initiative. He challenged us, he stretched our thinking, he would never take "no" for an answer. His energy and insight will be missed.

The best, perhaps the only fitting tribute to Andy Nichols is to continue his work — our work — on behalf of Arizonans whose health and welfare were central to his life's work.

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Health Care Coverage in Arizona

January 2002

An Overview

The University of Arizona's Southwest Border Health Research Center has conducted a detailed assessment* of health care coverage in Arizona under contract with the Arizona Health Care Cost Containment System (AHCCCS). This overview summarizes the most important findings of the assessment concerning health insurance coverage, the uninsured, and many factors that influence the extent of health insurance coverage in this State. This overview is intended to provide legislators, providers and advocates with a baseline of information from which to develop policies and programs that ensure an affordable *and accessible* statewide, health care system that meets the needs of all the state's citizens. *The authors believe that this overview is merely the beginning — a baseline — to understanding the unique issues which affect our state's health care marketplace and the people it serves.* For a more complete analysis and supporting data, please refer to the full Assessment.

* *The University of Arizona Rural Health Office (UA RHO) submitted a State Planning Grant application to the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS) to address the issues of affordable, accessible health insurance for the uninsured in Arizona. The one year grant was awarded in March 2001 and is administered by the Arizona Health Care Cost Containment System Administration (AHCCCSA).*

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The Uninsured and Factors that Affect Health Insurance Coverage

Three years ago, Arizona ranked second worst among all states in the number of uninsured residents. Today, it is still ninth from the bottom among all states. State policy makers increased their efforts to reach the uninsured with health benefits by adopting the Premium Sharing Program, KidsCare, and approving expansions of eligibility for AHCCCS. I*n 2000, 16% of the state's population remained uninsured — approximately 805,000 individuals.*

The principal causes of lack of insurance are: 1) low hourly wage, 2) premium cost, 3) the individual's self-assessment of the risk of needing health care services, 4) language, and 5) immigration status. Understanding these motivations more clearly and identifying other less obvious issues are key to developing programs that will close existing gaps in health care coverage.

We know that the primary source of health insurance for workers is employer-sponsored benefits. But having health insurance is dependent on two factors: 1) whether the cost of the benefit is affordable for the employer, and 2) if the employee is required to contribute to the cost of health insurance, can he/she afford it? The majority of the uninsured are the so-called working poor — individuals who earn too little to pay for health benefits, but too much to qualify for public programs, like AHCCCS. Low-wage workers, unskilled laborers, service workers, and employees in small businesses are the most likely to be uninsured, although most are employed full-time. Young adults make up a high percentage of low-income workers and have a higher likelihood of being uninsured than any other age group.

Research indicates that minorities are more likely to be uninsured than Whites. In Arizona, Hispanics are twice as likely as Whites to be uninsured; with low income Hispanics having uninsured rates that are even higher. Compounding this situation is the fact that non-citizen Hispanics (many are legal residents) are three times more likely to be uninsured than Whites and two times more likely to be uninsured as Hispanics who are citizens. But, it is important to dispel a myth that has arisen regarding the uninsured - that the rise in the number of uninsured is caused by recent immigrants. As the Institute of Medicine notes in its new study, *Coverage Matters: Insurance and Health Care*, *"...over 80% of the net increase in the size of the uninsured population consisted of U.S. Citizens."* American Indian populations in Arizona share the experience of the state's Hispanic residents — they are more often uninsured than their White neighbors.

Of final note, rural residents are more likely to be older, poorer and less healthy than their urban counterparts and they are more likely to be uninsured. Like other uninsured populations, most of these households have at least one full-time worker. Older adults (aged 45-64) account for a large percentage of the uninsured in rural communities.

Findings and Policy Implications

The findings contained in this Overview and in the complete Assessment have significant implications for health coverage policies in Arizona:

- **A higher proportion of the Arizona population was uninsured in 2000 than the national average.**

  Despite improvements in recent years, 16.0% of Arizonans were uninsured in 2000 compared with a national average of 14%. Thus, an estimated 805,000 Arizonans were uninsured. When addressing the problems of extending health insurance coverage, Arizona starts with a larger problem.

- **The population and employment characteristics of the Arizona population are associated with lower rates of insurance coverage.**

  Health insurance coverage is lower among minority and rural populations, for those in lower paying jobs and those working for small employers. Since these populations are heavily represented among Arizona's residents, addressing their needs is a critical focus for public policymakers.

- **The improvements that occurred in health insurance coverage in 1999 and 2000 are probably attributable to the robust economy in those years, as well as to some effects of state policies that increased the number of persons eligible for state-assisted programs, especially among children.**

  The declining economy in 2001 is likely to interrupt this favorable trend putting more burden on existing and proposed public policies to improve coverage.

- **Arizona's reliance on service industries may make it vulnerable to serious upswings in the number of uninsured if the economy falters.**

  Arizona's service industry provides 82.4% of the state's employment. Productivity gains in this sector (i.e., increases in employee output per hour) are difficult to achieve. As health-care costs escalate at a more rapid rate than productivity and income, higher rates of uninsurance may occur in this particular sector because health insurance becomes more expensive relative to business income.

- **The recent strong increases in private health insurance premiums will make it difficult to reverse any downturn in the number of uninsured when the economy recovers.**

  The favorable trend in health insurance coverage in Arizona during 1999 and 2000 is likely to be reversed by market trends. That means that returning to the favorable trend of recent years will be difficult even when the economy begins to improve.

- **The health care providers who are part of the "safety net" play an important role in providing health services to those who fall into the gaps in insurance coverage.**

  During a declining economy, the role of these programs is likely to increase. State policies to extend insurance coverage are unlikely to eliminate all gaps in coverage; therefore, attention to sustaining the role of the safety net providers will be necessary.

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Findings and Policy Implications

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- **The high costs of health care are a formidable barrier to extending health insurance coverage. The high penetration of managed care in Arizona, including the highly effective managed care model advanced by AHCCCS, has helped contain health care costs in Arizona compared with the U.S. average.**

  Arizona has been a strong example of the effectiveness of managed care in restraining health care costs, both for employer-based health insurance and for public programs. However, health care costs and insurance premiums are once again surging upward at a time when the stricter models of managed care are in retreat in Arizona and nationally. One dramatic example of this retreat is the withdrawal of Medicare + Choice programs from rural counties. Higher costs, coupled with a slowing economy, will increase the difficulties of maintaining, let alone of extending, coverage by both public and private sector health insurance programs.

- **The cost of providing care to undocumented and other uninsured immigrants is a serious problem for Arizona's providers.**

  Paying for health care for undocumented immigrants is a problem for Arizona. The full extent of this problem is unlikely to be shown by the data presented in this Overview. But anecdotal information suggests that a special burden is placed on the safety net providers as health insurance, public or private, is usually not available for this population. Dealing with this reality raises complicated issues for federal, state, and local policies and budgets.

Important Note about Current Trends Affecting Health Insurance Coverage

The Assessment is a report based on data. However, data and the trends reflected by those data have a *very important* limitation as guides for current and future policy actions. Data describe the past, and trends based on the past may be misleading if major changes in critical factors are underway.

For example, a report by John Holahan of the Urban Institute published in *Health Affairs*, is foretelling. That report's major finding from the 1994-1998 period is that the small increases in employer-based coverage were caused in large part by persons moving into higher paid jobs during that economic period of growth. Further analysis shows that the increase occurred in the lower income brackets (coverage actually declined in the upper brackets), supporting the conclusion that during this time of prosperity persons moved into jobs that offered insurance. "All of this suggests that the lack of insurance would have increased much faster had it not been for the strong economy and the associated increase in incomes, as well as the lower rates of premium increases. *If these conditions were to change, employer-sponsored coverage could again decline…"*

In Arizona, after a very long period of economic growth, accompanied by moderate increases in the costs of health care, the economy entered a period of decline just when health care costs began to increase rapidly. The effects on the economy of the events of September 11, 2001, and especially the reduction in the tourism industry, have had a strong effect in Arizona. Unemployment rates are up sharply. (A recent study at Massachusetts Institute of Technology indicates that for every 100 persons that lose their jobs, 85 become uninsured.)

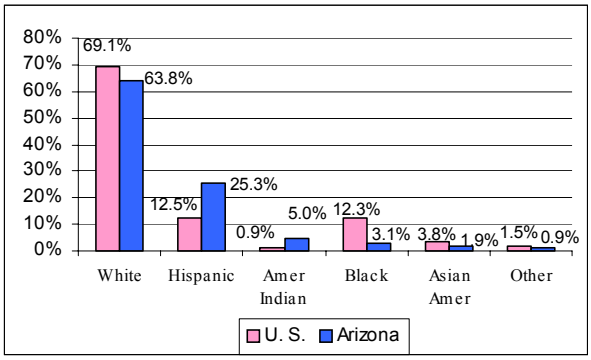
Arizona Characteristics that Influence Health Care Coverage

Population and Geographic Characteristics

According to the 2000 Decennial Census, Arizona experienced a 40% increase in population since 1990. With more than 5,130,632 residents, it is the nation's sixth largest state and, although most of its acreage is frontier and rural, the majority of the population resides in urban centers. Arizona is one of four U.S.-Mexico border states and consists of 15 counties; it is bordered to the north by the states of Utah and Nevada, to the east by New Mexico, to the west by California and to the south by Mexico. The state's culture and history are replete with influences assimilated from the Spanish Empire to Mexican, Central and South American immigrants. At the same time, the state is home to 21 American Indian tribes, including the Navajo, the largest on-reservation population in the United States.

In 2000, there were significant race/ethnic differences between the U.S. and Arizona. Arizona had fewer Whites, Blacks, and Asian Americans than the U.S., but more Hispanics and American Indians (see Figure 1 for details). Between 1990 and 2000, the number of Whites and American Indians decreased while Hispanic, Black and Asian American populations increased. Finally, the state's median household income of $38,537 trails the national median for household income, but the state's unemployment rate was lower than the national average.

Figure 1. Comparison of Race/Ethnicity Distribution in United States and Arizona



Source: U.S. Census 2000

Economically, the state represents a diverse mixture of professions and incomes as retirees, military, and high tech industry leaders reside in communities with teachers and farm laborers. While major industries in the state vary from county to county, the main economic sectors include: service, trade and manufacturing. Mining and agriculture are also significant, although they tend to be more capital than labor intensive. The service sector is the single largest employer, with 721,500 employees in 2000.

Business and Employment Characteristics

The structure of employment in the Arizona economy is somewhat different from the rest of the U.S. The largest employment sector in Arizona is in the service-producing industries, which provide 82.4% of all employment - a figure that outpaces the U.S. (77.3%). In Arizona, the three goods-producing industries (mining, construction, and manufacturing) employ comparatively fewer workers (17.6%) than the U.S. as a whole (22.7%). The largest difference in employment distribution is in the manufacturing sector, where Arizona trails the U.S. (9.7% vs. 15.4%). The pattern of employment in Arizona is almost precisely what one would expect in a state that earns

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Arizona Characteristics that Influence Health Care Coverage

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Business and Employment Characteristics

so much of its income from tourism.
The smallest firms, those with fewer than 10 employees, comprise 74.4% of all firms in Arizona while large firms, those with 1,000+ employees, comprise 0.2% of all firms. But, the 87,131 smallest employers employ only 10.2% of all employees, whereas the 197 largest employers employ 23.0% of the labor force.

The Arizona Health Care Marketplace

The state has one of the most aggressive and competitive health care marketplaces in the United States. Much of its development can be traced to the successful implementation of the Medicaid managed care demonstration, the Arizona Health Care Cost Containment System (AHCCCS).

Like other state Medicaid programs, AHCCCS provides general medical services to categorically eligible poor and low-income individuals in households where income does not exceed federally approved standards. Arizona's program organizes providers into prepaid, capitated networks, coordinates care, and promotes prevention and wellness - thereby reducing the health cost escalation experienced in traditional, fee-for-service Medicaid programs. As a result, AHCCCS has secured national attention for its success in changing the way providers deliver, and patients receive, medical services.

While initially intended to revolutionize the way services were provided to the poor, AHCCCS may have inadvertently instigated similar reforms in the private insurance market. This can be demonstrated by two facts: the high percentage of residents who received health care benefits through managed care insurers (87.5%) and the state's low health care expenditure per capita (ranked 41st). In fact, Arizona is in the top ten states in HMO penetration rates and had a higher penetration rate (47.8%) in 1998 than the U.S. (38.8%). Moreover, there was a steady increase in HMO enrollments from 1996 to 1999.

While it can be said that these changes in the health care system have been positive, one problem continues to vex policymakers. *During the last decade, the number of uninsured remained high.*

Only three years ago, Arizona ranked second worst among all states in the number of uninsured residents. The situation has improved slightly, but it is still the ninth from the bottom of all states in the percentage of people covered. State policy makers increased efforts in the last five years to reach the uninsured with health benefits by approving expansions of eligibility for Medicaid, and although an improved economy drove employment figures higher, the number of uninsured did not decline significantly.

With the recent unease in the economic sector, and a slow upswing in unemployment, there is concern that the ranks of the uninsured may grow too fast, overwhelming current programs as well as efforts to close the gap between the insured and uninsured in Arizona.

A Summary of the Detailed Report Contained in the Full Assessment

Ideally, an assessment would include data from three sources - national studies that include state level data, information from health care coverage programs, and population surveys conducted statewide. However, the issues of time and limited resources made it impossible to conduct a statewide survey. So, consistent with appropriate research criteria, survey data have been gleaned from national surveys conducted by academic and other research organizations. For the purpose of this Overview and the complete Assessment, both national and Arizona data were used.

Defining the Term 'Uninsured'

Health policy researchers use many definitions of the uninsured, frequently dependent on the definition used by the data sources, so the national and state uninsured numbers and uninsured characteristics figures reported in the literature often vary or appear to contradict one another. Differences can be attributed to the sampling methods, sampling numbers, and over- sampling (for instance, minority populations).

Other issues that may cause confusion are surveys that pool multiple years of survey data, or the types of questions asked about health care coverage. Surveys often rely on self-reported information and memories of events may be hazy, leading to mis-reported data. How data are reported can also be a problem. Surveys may state the number of uninsured *as a percentage of the total state population* or might identify the uninsured as a percent *of the total non-elderly state population* (those under the age of 65). In addition, technical differences over time are due to changes in how data are reported.

In reality, one can only assess relative uninsured rates over time by comparing the uninsured numbers using the same survey data — a method that is not in place in Arizona. To establish a baseline, the authors of this report had to make specific decisions about the data to be used. In this assessment, *the total population* of the uninsured is used because it provides a more complete picture of Arizona's uninsured population. However, this means that because those persons over age 65 are more likely insured (Medicare) than younger persons, the reported rates of uninsured, as a percent of Arizona's total population, *are generally lower* than if the population was restricted to those persons under age 65 (non-elderly). To correct this problem, some researchers (and this Overview and the Assessment) use the pooling of multiple-year data to describe *trends* in the number of uninsured.

Finally, the report will use year 2000 as the base year for information. That is because the state and county population numbers from the 2000 Census are more current and provide a more accurate count than the population estimates that accumulated during the decade following the 1990 Census. (For example, there was a significant difference between the 2000 population estimates (5,045,275) and the 2000 census (5,130,632) for Arizona.)

For a detailed description of all data sources and information used in the Assessment, see the *Technical Notes and Data Sources Appendix* at the back of the Assessment.

Health Care Coverage and Health Care Costs in Arizona

National statistics for the total population indicate that the United States as a whole had higher rates of health care coverage on average than did Arizona from 1996 to 2000. However, Arizona had a higher increase in employer-sponsored health care coverage from 1998 to 1999, while the U.S. increase was minimal. Most of Arizona's health care coverage rate increase can be attributed to increases in employer-sponsored health insurance driven by strong state and national economies, increased AHCCCS enrollment and a change in the Current Population Survey definition of coverage.

Costs of private health insurance for individuals covered by employer-based and publicly subsidized insurance are described briefly below and in the complete Assessment. The primary focus is the cost of premiums and the required contributions by involved parties (i.e., employer, government, employee or beneficiary).

Arizona Health Care Expenditures Overview

In Arizona during 1998, $14.78 billion were spent on health care, or 11% of the gross state product (GSP measures the market value of goods and services produced by labor and property located within a state). To place this issue in context, while Arizona's rate of expenditure falls between the states with the highest and lowest proportion of health care expenditure as a component of GSP — West Virginia at 17.6% and Wyoming at 8.0% — its uninsured rate outpaces both states (24% vs 17.2% and 16.9% respectively. The three highest health care expenditure categories for Arizona in 1998 were physicians and other professional services, $5.14 billion or 34.7%; hospital services, $4.98 billion or 33.7%; and drugs and other medical non-durables at $2.07 billion. (Note that the amount captured under hospital services does not reflect charges from non-hospital facilities such as ambulatory surgical centers.)

Arizona's Health Care Coverage and Cost

Arizona's Private Insurance Market

The proportion of Arizona private establishments offering health insurance coverage increased slightly from 1996 to 1999. The number of persons estimated to be covered by employment-based health insurance is 2,996,000, or 59.4% of the total population in 2000. The larger the firm and the more full time employees, the more likely it was to provide health benefits. Almost two-thirds of Arizona's workers were enrolled in their employer's health insurance program. Part-time and low-wage workers are less likely than full-time workers to have health benefits. One reason may be that few firms with a majority of these workers offer health insurance to employees.

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Arizona's Health Care Coverage and Cost

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Arizona's Private Insurance Market

Employer-Sponsored Health Insurance

Coverage

In and of itself, firm size does not reveal whether the firm will offer health insurance. Firms usually grow larger if they can exploit economies of scale, which tends to make them more efficient, hence more productive. The fact that larger firms in the state have lower rates of uninsurance than smaller firms simply indicates that the larger firms are probably in industries where physical capital can more easily be combined with labor for greater increases in productivity. Large firms that have achieved productivity gains can more easily afford to pay for health insurance.

However, for the largest employer in Arizona — the service industry — productivity gains (i.e., increases in employee output per hour) are difficult to achieve. Therefore, as healthcare costs escalate at a more rapid rate than productivity and income, we see higher rates of uninsurance simply because health insurance becomes ever more expensive relative to business income.

Cost

In 1999, the U.S. population had a higher proportion of persons with employer-sponsored health care coverage (63.5%) than Arizona (56.7%), but Arizona employers paid less, on average, for employee health benefits than elsewhere in the U.S. From 1996 to 1999, the national average single premium dollar cost rose from $1,991.64 in 1996 to $2,324.76 in 1999. Arizona's overall premium dollar cost rose from $1,791.77 to $2,097.33 during this time period, but fell slightly between 1998 and 1999.

Further, in 1999, Arizona employees paid a lower percentage of wages and average dollar amount of the premium (17.4% and $365.90) than other U.S. workers (18.1% and $420.35). During the period 1996-1999, both the national and Arizona average family premium cost rose. But Arizona employees continued to pay a lower average family premium than other U.S. families in 1999 ($5,509.34 vs $6,058.12).

Consolidated Omnibus Reconciliation Act (COBRA)

Coverage

Requires employers with 20 or more employees to continue to offer coverage in their group health plan to certain former employees, retirees, spouses, and dependent children.

Cost

Individuals may be required to pay the entire group rate premium plus a surcharge of up to 2% to cover administrative costs.

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Arizona's Health Care Coverage and Cost

(Continued)

Publicly-Subsidized, Private Health Insurance Coverage

HealthCare Group

Coverage

The Arizona Legislature established HealthCare Group (HCG) in 1988 when private carriers began withdrawing from the small employer market. Administered through AHCCCS, the program offers a choice of prepaid insurance coverage through AHCCCS contractors (HMOs) to businesses with one-to-50 employees. The products are intended to be similar to those offered in the private insurance market. Participating health plans are required to accept full-time workers regardless of health status, and to charge a modified community rate. In June 2000, there were 11,559 employees covered through 3,610 small businesses.

Cost

The HCG premiums are fully paid by employers and/or employees (there is no HCG requirement regarding the premium share contributed by employer and employee). Because HCG premiums are established at a modified community rate, the cost of HCG coverage for high-risk individuals is lower than medically underwritten market rates, but higher than market rates for healthy employees. Premiums are determined by the level of co-pays, deductibles, cost-sharing, age and by type of product selected.

Premium Sharing Program

Coverage

In 1998, the state created a pilot program, funded from a special tax on tobacco products, to provide health care coverage on a sliding fee scale to uninsured, low income families with household income below 200% FPL who do not qualify for Medicaid or Medicare. Like HealthCare Group, this program is administered by AHCCCS. Initial insurance offerings were only available in four counties, but the program has been expanded to all 15 counties. In 2000, 7,107 persons were enrolled in the Premium Sharing Program.

Cost

The enrollee shares responsibility with the state for the cost of monthly premiums on a sliding fee scale. The portion of the premium paid by the state is determined by the household gross annual income, though family premium payments may not exceed 4% of income for a family (or 2% for a single person). The average enrollee contribution was $21 per month in 2000. There is a sub-program within the Premium Sharing Program, designed to meet the medical needs of chronically ill people. These enrollees pay the full premium of $410 per month per family member enrolled.

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Arizona's Health Care Coverage and Cost

(Continued)

Publicly-Sponsored Health Coverage

Health care coverage may be provided by the federal or state government. Coverage is generally provided for welfare recipients, federally recognized tribal nations, active duty personnel and their dependents, veterans, retirees and disabled individuals. Some programs in this sector are authorized by the federal government, but responsibility for services and funding is shared with the states (in Arizona, AHCCCS). For the purpose of this Overview and the full Assessment, this sector also includes privately-sponsored, "safety net" (charitable) programs.

The Arizona Health Care Cost Containment System (AHCCCS)

Coverage

AHCCCS, Arizona's Medicaid managed care program, is a joint Federal-state health program providing general medical services to low income, indigent and disabled populations. Enrollment (not including KidsCare or ALTCS enrollees) recently recovered from a decline in the latter half of the previous decade — from 453,867 in 1996 to 402,013 in 1998. In 2000, a total of 475,627 individuals were enrolled in AHCCCS, more than 60% of these were aged birth to 19 years.

Cost

There is no charge for services provided under the AHCCCS benefit package.

Arizona Long Term Care Services (ALTCS)

Coverage

Arizona Long Term Care Services provides care to blind, disabled or elderly individuals age 65 and older who need institutional (skilled) care. Based on income, which may not exceed $1,590 per month (300% of the federal Supplemental Security Income [SSI] standard); resources may not exceed $2,000 for a single person, $3,000 if married. The program is a component of AHCCCS and administered by the agency. On December 1, 2000, there were 30,602 enrolled in the ALTCS program, a 35.3% increase since 1996.

Cost

There is no charge for services provided under the ALTCS benefit package.

State Children's Health Insurance Program (SCHIP) — KidsCare

Coverage

KidsCare (Arizona's Children's Health Insurance Program) is a joint federal/state program for children under the age of 19 who are not Medicaid eligible, in households with income below 200% FPL ($2,132 per month of $34,100 per year for a family of four in 2000). In 2000, there were 42,871 children enrolled in the program.

Cost

There is a small premium for families with income between 150% and 200% FPL. For households between 151-175% FPL, the premium is $10 for one child and $15 maximum for more than one child. For households with income between 176% and 200% FPL, the fee is $15 for one child and $20 maximum for more than one child.

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Arizona's Health Care Coverage and Cost

Publicly-Sponsored Health Coverage

(Continued)

Medicare

Coverage

Medicare is the nation's largest federally financed health insurance program ($216.6 billion). It covered approximately 39 million Americans (38,824,855) in 1998. It provides health insurance to people aged 65 and over and those who have permanent kidney failure and certain people with disabilities. Since the early 1990s, the Medicare population enrolled in HMOs has grown steadily. In 1998, Arizona had the second highest penetration of HMOs into the Medicare beneficiary population at 41.8%. The number of Medicare beneficiaries in Arizona has grown from 638,942 in 1996 to 690,625 in 2000.

In 1999, Arizona had 577,000 aged and 81,000 disabled persons enrolled in Hospital Insurance (HI). Supplemental Medical Insurance (SMI), also known as Medicare Part B, is available to all HI enrollees for a small premium that is subsidized by the federal government. SMI covers additional services like home health, limited long term care, rehabilitation, etc.

Cost

HI (Part A) is provided automatically, and free of premiums, to persons age 65 or older who are eligible for Social Security or Railroad Retirement Benefits. Almost all persons entitled to HI choose to enroll in SMI, because SMI is heavily subsidized by the Federal general tax fund. The monthly SMI (Part B) premium only amounts to 25% of the actuarial value of the SMI benefit. Thus, in the year 2000, while the monthly value of the SMI benefit was worth $182.00, the SMI enrollee only paid a $45.50 premium and the Federal government paid the remaining $136.50.

In 1999, HI had 39.1 million enrollees (33.9 million aged and 5.2 million disabled), and HI benefit payments totaled $128.8 billion. SMI covered 37.0 million persons (32.3 million aged and 4.7 million disabled) and SMI benefit payments totaled $80.7 billion.

Indian Health Service

Coverage

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is responsible for providing federal health services to American Indians and Alaska Natives living on federal tribal land. The IHS is the principal federal health care provider and health advocate for Indian people. There were 162,943 American Indians living on Arizona reservations in 2000.

Cost

In order to be eligible for services, tribal members must reside within federal tribal land. Members are not responsible for any co-payments for medical, dental, pharmaceutical, or other direct health services.

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Arizona's Health Care Coverage and Costs

(Continued)

Publicly-Sponsored Health Coverage

CHAMPUS — Tricare

Coverage

Tricare is the worldwide health care program for active duty and retired uniformed members and their families provided by the Department of Defense. The program consists of three different options: Tricare Prime, a managed care option; Tricare Standard, a fee-for-service option (formerly the CHAMPUS benefit); and Tricare Extra, a preferred provider option. All active duty personnel are required to enroll in Tricare Primte, while family members and retirees may choose from the three plan options. Medicare-eligible beneficiaries age 65 and over may also choose from any of the three plans, or the Tricare For Life option which is a Medicare supplement. Arizona Tricare enrollment for 2000 was 124,117.

Cost

There are no premiums or co-pays for active duty members and their families for any of the options. Tricare Prime features no annual deductible for active duty members and their families. Tricare Extra and Standard feature an annual deductible and a 15% cost share for using providers outside the network. Retirees and their family members are only charged an enrollment fee depending on individual or family coverage, if they choose the Prime option, while the Extra and Standard options carry no enrollment fee. There are co-pays for retirees and their family members with the three options. Also, there is a 20% cost sharing fee for Standard option. The cost of Tricare for Life is covered by the Medicare Part B premium.

Veterans Affairs (VA)

Coverage

The Department of Veterans Affairs (VA) provides health benefits to eligible veterans, primarily through VA health facilities augmented by contracts with providers in the private sector. There were 509,009 Arizona veterans in 2000 and more than 84,000 received care from the VA system. Those veterans who have other coverage (such as Medicare) generally do not use the system. Veterans are classified into seven categories.

Cost

Veterans in Category 7, which includes veterans who do not meet the criteria for Categories 1-6, and who have nonservice-connected disabilities, agree to copayments for all services. Other categories have modest copayments for prescription drugs, for nonservice-connected disabilities, unless determined unable to pay. If the veteran is covered by other private health insurance, the VA will bill the other insurance for services for nonservice-connected disabilities. Private insurance coverage may offset copayments.

Arizona's Safety Net

Coverage

The health care safety net is defined as those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients. The core safety net providers include public hospital systems; federal, state, and locally supported community health centers or clinics; local health departments; and special service providers. In addition, other health care providers with demonstrated commitment to serving the poor and uninsured, fulfill the role of safety net provider.

Cost

The charge for services is based on one's ability to pay (sliding fee scale for those not enrollled in Medicaid).

Arizona's Uninsured Population

The uninsured population is not a single, homogeneous population that can easily be identified; it is made up of smaller sub-populations. When considering why more and more people do not have health insurance, one must take into account three basic economic factors: 1) per capita health-care costs, 2) employee productivity by industry, and 3) employee income (wages and benefits) by industry. In other words, if per capita health care costs is greater than the rate of increase in employee income, then a growing percentage of employee income will be spent on health care, or fewer employees will be covered.

According to the U.S. Census for 2000, 805,000 of the total population of Arizona were uninsured — ninth among all states in the U.S. As staggering as those numbers may sound, they actually represent an improvement over previous years. In 1999 and again in 2000, the number of uninsured in Arizona decreased more than 4% (see Figure 2). This follows a similar trend in national rates. Arizona's improvement can also be attributed to increases in employer-sponsored health insurance driven by strong state and national economies and an increase in AHCCCS enrollment. In fact, in 1998-'99, the state's increase was even greater than the national.

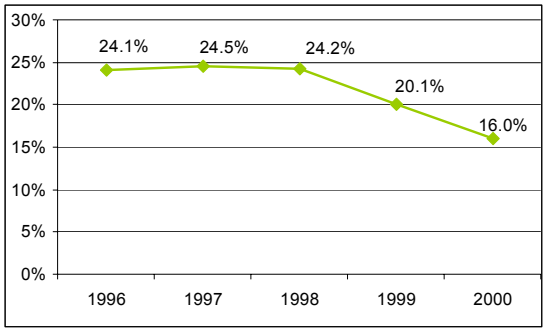

Figure 2. Arizona Uninsured Population Estimates 1996-2000

Characteristics Defining Arizona's Uninsured Population:

1. Those with income below 200% FPL, are more likely to be uninsured than higher income persons.
2. The unemployed are more often uninsured than employed persons.
3. Low-wage workers, unskilled laborers, service workers, and employees in small businesses are more likely to be uninsured than other workers.
4. Employees in the service sector, especially part-time and seasonal employees, are more likely to be uninsured than their full-time counterparts.
5. Employees of small firms are more likely to be uninsured than employees of large firms.
6. Those aged 18-24 are more likely to be uninsured than any other age group.
7. Young adult males are more likely to be uninsured than young adult females, as many more young women than men are eligible for AHCCCS (Medicaid).
8. Rural residents are more likely than their urban counterparts to be uninsured.
9. Older adults (aged 45-64) account for a large percentage of uninsured in rural communities.
10. Minorities are more likely to be uninsured than Whites.
11. Hispanics were twice as likely as Whites to be uninsured.
12. Hispanics are more likely to be uninsured than any other minority groups.
13. American Indian populations are more likely to be uninsured than their White neighbors.
14. Arizona's tribes register higher percentages of uninsured and underinsured populations than other state residents.

Barriers to Health Care Coverage in Arizona

Based on an analysis of Arizona's health care marketplace, many barriers exist currently that make it difficult for employees or individuals to obtain health care coverage. A few examples follow:

- **Employees in small businesses are more likely to be uninsured**.

  Small employers face higher costs than larger employers for providing the same benefits, so smaller firms are less likely to offer health insurance.

- **Lower-income workers, especially those who work part-time, cannot afford health insurance premiums**.

  Many Arizona jobs are low paying jobs such as farming, general labor, and service. According to the analysis cited earlier, while the primary source of health insurance is employer-sponsored health benefits, the prominence of tourism and other service industries in this state, along with disproportionately high numbers of small businesses and fewer benefits for workers, contribute to the higher rates in the number of uninsured.

- **A larger percentage of Hispanic workers struggle at the lowest end of the employment scale.**

  Because of the generally low economic condition of many Hispanic families in Arizona, it is not surprising to find that the uninsured rate among Hispanics is triple that of Whites.

- **Populations eligible for public programs do not know that they are eligible or do not know how to enroll**.

  A recent poll conducted by Harvard University, University of Maryland and Robert Wood Johnson Foundation found that only 29% of parents were aware of the new Children's Health Insurance Program.

- **Many low income persons are eligible for, but not enrolled in, public programs**.

  The largest program nationwide for low-income children is Medicaid, but an analysis based on 1996 Census Bureau data concluded that as many as 3.4 million uninsured children eligible for Medicaid were not enrolled.

- **Changes in public programs have had the effect of disenfranchising the lowest income families**.

  Many children eligible for Medicaid are not enrolled because their parents lost eligibility for cash assistance as states transformed their welfare program. These parents no longer go through routine recertification and, as a result, are not aware that their children may continue to be eligible for public programs like AHCCCS.

- **Changes in immigration laws have chilled public advocates' ability to find and enroll eligible populations in AHCCCS**.

  A 1999 workshop by the Health Care Financing Administration identified the following barriers to enrolling eligible immigrant populations in public programs: 1) fear that enrollment will lead to deportation; 2) fear of exposing an undocumented family member to deportation; 3) misinformation fueled by personal or anecdotal experiences; 4) cultural and language barriers; 5) lack of printed materials at appropriate literacy levels, in appropriate language and lack of interpreter services; 6) prejudicial attitudes of enrollment staff, and 7) inaccessible and inconvenient enrollment office locations and hours.

- **Low wages, employment instability, and reduced, nonexistent, or financially unattainable employee benefit packages remain the major causes of intermittent or inadequate health insurance coverage.**

  Parents may experience layoffs or change employment, and they often do not have adequate income to convert employment-based health policies to continue coverage for their families after involuntary layoffs.

- **Many tribal members who move away from their home reservation are not eligible for some services.**

  A member of a federally recognized tribe may obtain care at any IHS hospital or clinic if the facility has the staff and capability to provide the medical care. To receive Contract Health Services (CHS), the patient must reside in certain areas. Some tribally operated hospitals and clinics restrict services to members of their own tribe. Consequently, just because an individual is a member of a federally recognized tribe does not mean that he/she will be provided medical care at a tribally-operated hospital or clinic.

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Strategies to Address Barriers and to Enhance Coverage

Publicly-Sponsored Programs

The 45th Legislature, the First Regular Session, passed into law several Bills that have been implemented to overcome the barriers to health care coverage or/and expanded coverage needs. Selected examples follow.

- **AHCCCS Expansion - Proposition 204**

  The passage of Proposition 204 (The Healthy Arizona Initiative II) in November 2000 raised the AHCCCS eligibility from 34% FPL to 100% to cover the working poor and provide funding to six public health care programs. It has been estimated that 130,000 to 180,000 Arizona residents will benefit from this change. This could result in a 30% increase over current AHCCCS enrollment.

- **KidsCare**

  Legislation also authorized the state to pursue a waiver from the CMS (Centers for Medicare and Medicaid Services) to provide coverage to parents of children who are eligible for KidsCare. The waiver was approved in December 2001. It has been estimated that 25,000 to 26,000 parents could receive coverage under the waiver.

- **Premium Sharing Program Expansion**

  Legislation passed by the Arizona Legislature in 2001 continued and expanded the Premium Sharing Program from four to all 15 counties in the state. In addition, the eligibility standards were increased from 200% FPL to 250% FPL. It has been estimated that 5,000 to 7,000 individuals will benefit from this program.

- **Ticket to Work**

  Legislation passed in 2000 provides AHCCCS benefits to persons between the ages of 16-64, who meet SSI (Supplemental Security Income) eligibility criteria, have earned income below 250% FPL, and who are employed but have a disability. No resource requirement and income deductions for disability-related work expenses will be given.

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Strategies to Address Barriers and to Enhance Coverage

(Continued)

Privately-Sponsored Programs

Both state and national organizations, particularly those in the employment sector, have attempted to develop programs to address the needs of employers or workers without health insurance coverage. Following are two examples of innovative ideas:

- **TripleNet Health**

  Provides businesses or their employees an affordable medical service discount option. The Greater Phoenix Chamber of Commerce and the Arizona Independent Automobile Dealers Association participate. Since discounted services already exist within Point of Service plans, those discounts are sold to the working poor for less than the premiums they would otherwise pay for commercial insurance. At a cost of $21.95 per month an individual will be able to save up to 80% or more on medical care.

- **Defined Contribution Programs**

  Provide resources for routine and unexpected health care expenses, plus information and tools to help people make informed choices for their ongoing health care needs. Key elements are: a Personal Care Account (PCA), Health Coverage, and Health Resources. In the PCA, the employer deposits a certain amount into each employee's PCA yearly. These dollars are then used to pay for routine health and wellness needs. Funds remaining in the account at the end of the calendar year rollover and stay with the employee.

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Strategies to Address Barriers and to Enhance Coverage *(Continued)*

Community-Sponsored Programs

Community-based outreach initiatives have been implemented to increase the enrollment of families and children in AHCCCS and KidsCare. Some of these are described below.

- **AHCCCS Outreach Programs**

  In 2001, seven grants were awarded by AHCCCS to identify and enroll families and children in Medicaid and KidsCare through a partnership with community-based organizations that focused on outreach and application assistance. The marketing included the development of collateral materials, purchase of radio time, use of billboards, and participation in special events.

- ***Border Vision Fronteriza*** **(BVF)**

  In 1995, the Health Resources and Services Administration contracted with the University of Arizona Rural Health Office to implement the BVF Project. The project establishes community-based, state-driven, model outreach strategies that rely on lay health workers to enhance access to health services by underserved U.S.-Mexico border populations. In the third year of the project, outreach efforts focused on enrolling children into Medicaid and the SCHIP. As a result, hundreds of children in Santa Cruz and Yuma Counties have been enrolled into AHCCCS or KidsCare. In 2001, HRSA awarded another three-year contract to the Rural Health Office to continue the work of the BVF in enrolling children into Medicaid and SCHIP in Pima, Santa Cruz and Yuma Counties.

- **Baby Arizona**

  The Baby Arizona program addresses the state's low rate of prenatal care through a public/private partnership. The goal of the program is to get expectant mothers into care as early as possible, and to ensure that they continue that care and practice healthy habits during pregnancy.

- **Robert Wood Johnson Foundation**

  The Robert Wood Johnson Foundation is providing funds for the community-based project, "Covering Kids and Families" (CKF), a new four-year initiative in Arizona to increase access for adults and children to health services. The program has two goals: 1) to create a comprehensive insurance product for school children and 2) to facilitate the provision of preventive care for children.

Financing Strategies to Expand Insurance Coverage

Several strategies to enhance health care coverage that include financial incentives have been implemented or are under consideration, nationally, to reduce the number of uninsured and to encourage insurance regulation and market reform. The primary goals of these strategies are to reduce the financial risk and enrollee cost to the insurer, and the premium cost to the employer-employee or the individual purchaser. These include: private purchasing pools, full cost buy ins, and tax incentives.

Current Arizona Tax Deductions for Personal Health Care Expenditures

Current Arizona tax law gives a very substantial subsidy to health care expenditures, including health insurance premiums, for those individuals who itemize their deductions by allowing the deduction of health care expenditures in the calculation of their state income tax. The result is a substantial state subsidy for private health insurance, skewed toward those with higher incomes and/or high levels of health insurance. This state deduction is much more generous than the equivalent provision in the federal tax law.

Conclusion

Arizona has made significant progress in reducing the number of uninsured in the state from second highest in the number of uninsured residents in the nation in 1998 to ninth in 2000. However, there were still approximately 805,000 persons without health insurance in 2000.

Most of this improvement can be attributed to: a) the increase in employer-sponsored health insurance driven by the state's strong economy and b) the variety of strategies employed by the state to increase both private and public health care coverage in recent years (e.g., legislative actions, privately sponsored programs, community-sponsored programs, and financing strategies to expand insurance coverage).

The state continues to implement these and other strategies to reduce the number of uninsured as the unemployment rate continues to rise and the possibilities that the uninsured rates may rise again. It is important to continue these efforts if Arizona is going to build on the progress it has made in lowering the uninsured rates in the state.